
UNIT 2 BIPOLAR DISORDER

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2.0 INTRODUCTION

Bipolar disorder or manic-depressive disorder, which is also referred to as bipolar affective disorder or manic depression, is a psychiatric diagnosis that describes a category of mood disorders defined by the presence of one or more episodes of abnormally elevated energy levels, cognition and mood with or without one or more depressive episodes. The elevated moods are clinically referred to as mania or, if milder hypomania. Individuals who experience manic episodes also commonly experience depressive episodes, or symptoms, or mixed episode in which features of both mania and depression are present at the same time. These episodes are usually separated by periods of “normal” mood; but in some individuals, depression and mania may rapidly alternate, which is known as rapid cycling. In the present unit we will first discuss the symptoms and types of bipolar disorder, after that we will explain the causes of bipolar disorder and finally we will come across to the treatment and prognosis of bipolar disorder.

2.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the nature of bipolar disorder;
- Describe the symptoms of bipolar disorder;
- Understand the different types of bipolar disorder;
- Explain the causes of bipolar disorder;
- Describe the treatment and prognosis of bipolar disorder; and
- Analyse the difference between bipolar disorder and other forms of depressive disorder.

2.2 BIPOLAR DISORDERS

Although recurrent cycles of mania and depression were recognised as early as sixth century, but it was Kraepelin in 1899 who first introduced the term manic-depressive insanity and to clarify the clinical picture. Kraepelin described the disorder as a series of attack of delation and depression, with periods of relative normality in between, and a general favorable prognosis. Bipolar disorder has traditionally been thought to be much less common than depression.

Earlier it was opined that depressive disorders were four to five times more frequent than bipolar disorder. But recent studies disagree with this view and believe that depressive and bipolar disorder are really very similar (Bowden, 1993). The reason is that depression has traditionally been considered to be more common, and accordingly many individuals suffering from bipolar disorder are wrongly classified as suffering from unipolar disorder because a manic or hypomanic episode has not yet occurred. Sometimes, a person with severe episodes of mania or depression has psychotic symptoms too, such as hallucinations or delusions.

The psychotic symptoms tend to reflect the person's extreme mood. For example, psychotic symptoms for a person having a manic episode may include believing he or she is famous, has a lot of money, or has special powers. In the same way, a person having a depressive episode may believe he or she is ruined and penniless, or has committed a crime. As a result, people with bipolar disorder who have psychotic symptoms are sometimes wrongly diagnosed as having schizophrenia, another severe mental illness that is linked with hallucinations and delusions.

2.2.1 Symptoms of Bipolar Disorder

Bipolar disorder is distinguished from major depression by at least one episode of mania. Any given episode is classified as depressive, manic, or mixed, according to its predominant features. If individuals experience only one of these moods (for example, either mania or depression), they are said to suffer only Unipolar mood disorder. Since the experience of manic symptoms alone is extremely rare, almost all individuals with unipolar mood disorders suffer from unipolar depression.

If the individual alternates between experiences of depression and mania he/she is said to be suffering from a bipolar disorder. Bipolar disorder is a condition in which people experience abnormally elevated (manic or hypomanic) and, in many cases, abnormally depressed states for periods of time in a way that interferes with functioning.

2.2.1.1 Depressive Episode

A depressive episode has features typical of major depression, including depressed mood, anhedonia, psychomotor retardation, and feelings of pessimism and guilt. Sleeping and eating often increase. Delusions of guilt accompanied by self-loathings are common in psychotic depression, and some patients have hallucinations. Signs and symptoms of the depressive phase of bipolar disorder include persistent feelings of sadness, anxiety, guilt, anger, isolation, or hopelessness; disturbances in sleep and appetite; fatigue and loss of interest in usually enjoyable activities; problems in concentration, loneliness, self-loathing, apathy or indifference; loss of interest in sexual activity; shyness or social anxiety, irritability, chronic pain (with or without a known cause); lack of motivation; and morbid suicidal ideation. In severe cases, the individual may become psychotic – a condition also known as severe bipolar depression with psychotic features. Features of depressive form of bipolar disorders are usually clinically indistinguishable from those of major depression (Perris, 1992, American Psychiatric Association, 1994), although some studies report higher rates of psychomotor retardation, overeating, and oversleeping in the depressive phase of bipolar disorder (Cassano, et.al., 1992; Whybrow, 1997).

2.2.1.2 Manic Episode

A manic episode is defined as one or more than one week of a persistently elevated, expansive, or irritable mood plus three or more than three of the following additional symptoms:

Inflated self-esteem or grandiosity, decreased need for sleep, greater talkativeness than usual, persistent elevation of mood, flight of ideas or racing of thoughts, distractibility, and increased goal-directed activity.

People suffering from bipolar disorder commonly experience an increase in energy and a decreased need for sleep. A person's speech may be pressured, with thoughts experienced as racing. Attention span is low, and a person in a manic state may be easily distracted. Judgment may become impaired, and sufferers may go on spending sprees or engage in behaviour that is quite abnormal for them. They may indulge in substance abuse, particularly alcohol or other depressants, cocaine or other stimulants, or sleeping pills. Their behaviour may become aggressive, intolerant, or intrusive. People may feel out of control or unstoppable. People may feel they have been "chosen" and are "on a special mission" or have other grandiose or delusional ideas. Sexual drive may increase.

Manic patients may inexhaustibly, excessively, and impulsively involved in various pleasurable, high-risk activities (e.g. gambling, dangerous sports, promiscuous sexual activity) without insight into possible harm. Symptoms are so severe that they impair functioning. Typically, patients in a manic episode are exuberant and flamboyantly or colorfully dressed; they have an authoritative manner with a rapid, unstoppable flow of speech. Patients may make clang associations (new thoughts that are triggered by word sounds rather than meaning). Easily distracted, patients may constantly shift from one theme or endeavor to another. However, they tend to believe they are in their best mental state. Lack of insight and an increased capacity for activity often lead to intrusive behaviour and can be a dangerous combination. Interpersonal friction results and may cause patients to feel that they are being unjustly treated or persecuted. As a result, patients may become a danger to themselves or to other people. Accelerated mental activity is experienced as racing thoughts by patients and is observed as flights of ideas by the physician.

2.2.1.3 Hypomanic Episode

A hypomanic episode is a less extreme variant of mania involving a distinct episode that lasts four or more than four days and is distinctly different from the patient's usual nondepressed mood. Hypomania is generally a mild to moderate level of mania, characterised by optimism, pressure of speech and activity, and decreased need for sleep. Generally, hypomania does not inhibit functioning like mania. Many people with hypomania are actually in fact more productive than usual. Some people have increased creativity while others demonstrate poor judgment and irritability. Many people experience hypersexuality. These persons generally have increased energy and tend to become more active than usual. They do not, however, have delusions or hallucinations. During the hypomanic period, mood brightens, the need for sleep decreases, and psychomotor activity accelerates. For some patients, hypomanic periods are adaptive because they produce high energy, creativity, confidence, and supernormal social functioning. Many do not wish to leave the pleasurable, euphoric state. Some function quite well, and in most, functioning is not markedly impaired. However, in some patients, hypomania manifests as distractibility, irritability, and labile mood, which the patient and others find less attractive.

2.2.1.4 Mixed Episode

A mixed episode blends depressive and manic or hypomanic features; the criteria for both mania and depression are met. For example, patients may momentarily switch to tearfulness during the height of mania, or their thoughts may race during a depressive period. Often, the switch follows circadian factors (e.g. going to bed depressed and waking early in the morning in a hypomanic state). In at least one third of people with bipolar disorder, the entire episode is mixed. A common presentation consists of a dysphorically excited mood, crying, curtailed sleep, racing thoughts, grandiosity, psychomotor restlessness, suicidal ideation, persecutory delusions, auditory hallucinations, indecisiveness, and confusion. This presentation is called dysphoric mania (i.e. prominent depressive symptoms superimposed on manic psychosis).

2.2.2 Classification of Bipolar Disorder

In DSM-IV-TR and ICD-10 bipolar disorder is conceptualised as a spectrum of disorders occurring on a continuum. The DSM-IV-TR lists three specific subtypes and one for non-specified:

- Bipolar I Disorder
- Bipolar I Disorder
- Cyclothymia
- Bipolar Disorder NOS (Not Otherwise Specified)

2.2.2.1 Bipolar I Disorder

Bipolar I Disorder is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. The symptoms of mania or depression must be a major change from the person's normal behaviour. A person with bipolar disorder experiences episodes of mania and, usually, major depressive episodes as well. A very small number of people may experience one or more periods of mania without ever experiencing depression (Goodwin and Jamison, 1990).

2.2.2.2 Bipolar II Disorder

Bipolar II Disorder is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes. Hypomanic episodes do not go to the full extremes of mania (*i.e.*, do not usually cause severe social or occupational impairment, and are without psychosis), and this can make bipolar II more difficult to diagnose, since the hypomanic episodes may simply appear as a period of successful high productivity and is reported less frequently than a distressing, crippling depression. Thus bipolar II disorder differs from Bipolar I in that – rather than experiencing one or more florid, dramatic manic episodes – the manic behaviour is present to a lesser degree. People who experience a hypomanic episode may not see it as pathological, although those around them may be concerned about the erratic behaviour they see.

2.2.2.3 Cyclothymia

Cyclothymia, or Cyclothymic Disorder, is a mild form of bipolar disorder. People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years. However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder. Symptoms of cyclothymic disorder are depressed mood for most of the day, for more days than not, for one year, including the presence of two of the following symptoms: poor appetite or overeating; insomnia/hypersomnia; low energy/fatigue; poor concentration; feelings of hopelessness. Symptoms are less severe than those of a major depressive episode but are more persistent. A history of hypomanic episodes with periods of depression that do not meet criteria for major depressive episodes. There is a low-grade cycling of mood which appears to the observer as a personality trait, and interferes with functioning.

2.2.2.4 Bipolar Disorder NOS (Not Otherwise Specified)

Bipolar Disorder Not Otherwise Specified (BP-NOS) is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for either bipolar I or II. The symptoms may not last long enough, or the person may have too few symptoms, to be diagnosed with bipolar I or II. However, the symptoms are clearly out of the person's normal range of behaviour. This is a catchall category, diagnosed when the disorder does not fall within a specific subtype. Bipolar disorders NOS can still significantly impair and adversely affect the quality of life of the patient.

2.2.3 Causes of Bipolar Disorder

Although causes of bipolar disorder likely vary between individuals. But studies suggest that both biological and psychological factors seem to play a role in determining whether a person will develop symptoms of bipolar disorder.

2.2.3.1 Biological Factors

Studies conducted on the families of people diagnosed with bipolar disorder show that there is strong tendency for other family members also to have higher than expected risk for a mood disorder of some type including bipolar disorder (Mitchell et.al., 1993). Results of studies indicated that about nine percent of the first degree relatives of a person with bipolar illness can also be expected to have bipolar disorder (nine times the rate of the disorder in the general population) (Katz and McGuffin 1993; Plomin et.al., 1997). Although family studies cannot by themselves establish a genetic basis for the disorder, results from twin studies also point to a

genetic basis. Twin studies have been limited by relatively small sample sizes but have indicated a substantial genetic contribution, as well as environmental influence.

The concordance rates for these disorders are much higher for identical twins than for fraternal twins (Kallman, 1958). The study of Bertelsen, Harvald, and Hauge (1977) estimated that monozygotic twins were three times more likely to be concordant (67 percent) for a diagnosis of bipolar disorder than were dizygotic twins (20 percent). About three-quarters of the affected cotwins had the same form of disorder (bipolar), but nearly one-quarter had unipolar disorder. This study further suggests that genes account for over 80 percent of the variance in the tendency to develop (that is liability for) bipolar depression. For bipolar I, the (probandwise) concordance rates in modern studies have been consistently put at around 40% in monozygotic twins (same genes), compared to 0 to 10% in dizygotic twins (Kieseppa et al., 2004). A combination of bipolar I, II and cyclothymia produced concordance rates of 42% vs. 11%, with a relatively lower ratio for bipolar II that likely reflects heterogeneity.

The overall heritability of the bipolar spectrum have been put at 0.71 (Edvardsen et al., 2008). There is overlap with unipolar disorder and if this is also counted in the co-twin the concordance with bipolar disorder rises to 67% (monozygotic) and 19% (dizygotic) (McGuffin et al., 2003) The relatively low concordance between dizygotic twins brought up together suggests that shared family environmental effects are limited, although the ability to detect them has been limited by small sample sizes.

Genetic studies of bipolar disorder have also used recombinant DNA technology in an attempt to locate genetic markers. The studies have suggested many chromosomal regions appearing to relate to the development of bipolar disorder, but the results are not consistent and often not replicated (Kato, 2007). Although the first genetic linkage finding for mania was in 1969 (Reich et al., 1969), the linkage studies have been inconsistent (Burmeister et al., 2008). Recent meta-analyses of linkage studies detected either no significant genome-wide findings or, using a different methodology, only two genome-wide significant peaks, on chromosome 6 and on chromosome 11.

Studies also suggest that abnormalities in the structure and/or function of certain brain circuits could underlie bipolar and other mood disorders. Imaging studies show how the brains of people with bipolar disorder may differ from the brains of healthy people or people with other mental disorders. For example, one study using MRI found that the pattern of brain development in children with bipolar disorder was similar to that in children with “multi-dimensional impairment,” a disorder that causes symptoms that overlap somewhat with bipolar disorder and schizophrenia (Gogtay, et al. 2007). This suggests that the common pattern of brain development may be linked to general risk for unstable moods. Some studies have also found anatomical differences in areas such as the amygdale (Strakowski, 1999), prefrontal cortex and hippocampus (Kempton et al., 2008). However, despite 25 years of research involving more than 7,000 MRI scans, studies continue to report conflicting findings and there remains considerable debate over the neuroscientific findings. Two fairly consistent abnormalities found in a meta-analysis of 98 MRI or CT neuroimaging studies were that groups with bipolar disorder had lateral ventricles which were on average 17% larger than control groups, and were 2.5 times more likely to have deep white matter hyperintensities.

Studies on conducted on the causes of mood disorder suggest that neurotransmitter also play important role in the development of bipolar disorder. As we know that neurotransmitter is brain chemical which helps in the transmission of information from one neuron to other at synapse. Neurobiological investigations suggest that norepinephrine and serotonin are such two transmitters which are associated with

depression. For example, Joseph and Schildkraut (1965) suggested that at least some forms of depressions are associated with low levels of norepinephrine. Conversely he suggested that elation or mania was associated with an excess of this neurotransmitter, which is called noradrenalin. This hypothesis, called *catecholamine hypothesis*, was developed after researcher had observed an unexpected drug effect. The drug reduced the levels of norepinephrine, which caused the people to become very depressed.

A second theory, known as *indolamine hypothesis*, suggests that low levels of serotonin (one of the indolamines) were associated with and perhaps caused depression (Glossman and Platman, 1969). It has also been observed that neurotransmitter system has many subtypes and interact in many complex ways with other neurotransmitters and neuromodulators (products of endocrine system). For example reserpine (used to reduce blood pressure) also affects dopamine, and in turn, causes to produce depression. Like reserpine, serotonin was also found to reduce levels of neurotransmitter and thus causes to increase the depression. Researchers also became interested in the endocrine system when they found that patients with such diseases which affect the endocrine system became depressed. Hypothyroidism, or Crushing's disease, affecting the adrenal cortex, leads to excessive secretion of cortisol and, often, depression.

It has been suggested that a hypersensitivity of the melatonin receptors in the eye could be a reliable indicator of bipolar disorder, in studies called a trait marker, as it is not dependent on state (mood, time, etc.). In studies, patients diagnosed as bipolar reliably showed a melatonin-receptor hypersensitivity to light during sleep, causing a rapid drop in sleep time melatonin levels compared to controls (Lewy et. al., 1985)). Another study showed that drug-free, recovered, bipolar patients exhibited no hypersensitivity to light (Whalley et.al , 1991). It has also been shown in humans that valproic acid, a mood stabiliser, increases transcription of melatonin receptors and decreases eye melatonin-receptor sensitivity in healthy volunteers while low-dose lithium, another mood stabiliser, in healthy volunteers, decreases sensitivity to light when sleeping, but doesn't alter melatonin synthesis (Hallam et al., 2005). The extents to which melatonin alterations may be a cause or effect of bipolar disorder are not fully known.

2.2.3.2 Psychological Factors

Evidence suggests that psychological factors play a significant role in the development and course of bipolar disorder, and that individual psychosocial variable may interact with genetic dispositions (Serretti & Mandelli, 2008). There is fairly consistent evidence from prospective studies that recent life events and interpersonal relationships contribute to the likelihood of onsets and recurrences of bipolar mood episodes, as they do for onsets and recurrences of unipolar depression (Alloy et. al., 2005). Environmental stressors can sometimes be important in setting off either an initial or additional manic episode.

Two-thirds of manic episodes experienced by patients in one study were preceded by a life related stress of some kind (Ambelas, 1987). Stressful events can also cause a manic episode in people with a past history of manic episodes or bipolar disorder. For example, when a major hurricane struck Long Island, New York, in 1985, there was a dramatic increase in manic episodes among patients with bipolar disorder who were being treated with lithium (Aronson and Shukla, 1987). All the people who relapsed already had a high level of stress in their lives and most lacked social support from a close, confiding relationship.

For each of these people the hurricane resulted in additional stress besides that from the storm itself. Findings of the studies also suggest that between a third and a half of adults diagnosed with bipolar disorder report traumatic/abusive experiences in childhood, which is associated on average with earlier onset, a worse course, and more co-occurring disorders (Gabriele et.al. 2006). The total number of reported stressful events in childhood is higher in those with an adult diagnosis of bipolar spectrum disorder compared to those without, particularly events stemming from a harsh environment rather than from the child's own behaviour (Louisa et. al., 2007).

Early experiences of adversity and conflict are likely to make subsequent developmental challenges in adolescence more difficult, and are likely a potentiating factor in those at risk of developing bipolar disorder (Miklowitz et. al., 2008).

2.2.4 Treatment

There are a number of pharmacological and psychotherapeutic techniques used to treat Bipolar Disorder. Hospitalisation may be required especially with the manic episodes present in Bipolar I.

Because bipolar disorder is a lifelong and recurrent illness, people with the disorder need long term treatment to maintain control of bipolar symptoms. An effective maintenance treatment plan includes medication and psychotherapy for preventing relapse and reducing symptom severity.

2.2.4.1 Medications

Some of the types of medications generally used to treat bipolar disorder are listed below:

2.2.4.1.1 Mood Stabilising Medications

These are usually the first choice to treat bipolar disorder. In general, people with bipolar disorder continue treatment with mood stabilisers for years. The following medications are commonly used as mood stabilisers in bipolar disorder:

Lithium (sometimes known as Eskalith or Lithobid) was the first mood-stabilising medication approved by the U.S. Food and Drug Administration (FDA) in the 1970s for treatment of mania. It is often very effective in controlling symptoms of mania and preventing the recurrence of manic and depressive episodes.

Valproic acid or divalproex sodium (Depakote), approved by the FDA in 1995 for treating mania, is a popular alternative to lithium for bipolar disorder. It is generally as effective as lithium for treating bipolar disorder.

More recently, the anticonvulsant lamotrigine (Lamictal) received FDA approval for maintenance treatment of bipolar disorder.

Other anticonvulsant medications, including gabapentin (Neurontin), topiramate (Topamax), and oxcarbazepine (Trileptal) are sometimes prescribed. No large studies have shown that these medications are more effective than mood stabilisers.

2.2.4.1.2 Atypical Antipsychotic Medications

These are sometimes used to treat symptoms of bipolar disorder. Often, these medications are taken with other medications. Atypical antipsychotic medications are called "atypical" to set them apart from earlier medications, which are called "conventional" or "first-generation" antipsychotics.

Olanzapine (Zyprexa), when given with an antidepressant medication, may help relieve symptoms of severe mania or psychosis. Olanzapine can be used for maintenance treatment of bipolar disorder as well, even when a person does not have psychotic symptoms.

Aripiprazole (Abilify), like olanzapine, is approved for treatment of a manic or mixed episode.

Aripiprazole is also used for maintenance treatment after a severe or sudden episode. As with olanzapine, aripiprazole also can be injected for urgent treatment of symptoms of manic or mixed episodes of bipolar disorder.

Quetiapine (Seroquel) relieves the symptoms of severe and sudden manic episodes. In that way, quetiapine is like almost all antipsychotics. In 2006, it became the first atypical antipsychotic to also receive FDA approval for the treatment of bipolar depressive episodes.

Risperidone (Risperdal) and ziprasidone (Geodon) are other atypical antipsychotics that may also be prescribed for controlling manic or mixed episodes.

2.2.4.1.3 Antidepressant Medications

These are sometimes used to treat symptoms of depression in bipolar disorder. People with bipolar disorder who take antidepressants often take a mood stabiliser too, because taking only an antidepressant can increase a person's risk of switching to mania or hypomania, or of developing rapid cycling symptoms.

2.2.4.2 Psychotherapy

In addition to medication, psychotherapy, or “talk” therapy, can be an effective treatment for bipolar disorder. It can provide support, education, and guidance to people with bipolar disorder and their families. Some psychotherapy treatments used to treat bipolar disorder include:

Cognitive behavioural therapy (CBT) helps people with bipolar disorder learn to change harmful or negative thought patterns and behaviours.

Family-focused therapy includes family members. It helps enhance family coping strategies, such as recognising new episodes early and helping their loved one. This therapy also improves communication and problem-solving.

Interpersonal and social rhythm therapy helps people with bipolar disorder improve their relationships with others and manage their daily routines. Regular daily routines and sleep schedules may help protect against manic episodes.

Psychoeducation teaches people with bipolar disorder about the illness and its treatment. This treatment helps people recognise signs of relapse so they can seek treatment early, before a full-blown episode occurs. It is usually done in a group. Psychoeducation may also be helpful for family members and caregivers.

2.2.5 Prognosis

For many individuals with bipolar disorder a good prognosis results from good treatment, which, in turn, results from an accurate diagnosis. Bipolar disorder can be a severely disabling medical condition. However, many individuals with bipolar disorder can live full and satisfying lives. Quite often, medication is needed to enable this. Persons with bipolar disorder may have periods of normal or near normal functioning

between episodes. Ultimately one's prognosis depends on many factors, several of which are within the control of the individual. Such factors may include: the right medicines, with the right dose of each; comprehensive knowledge of the disease and its effects; a positive relationship with a competent medical doctor and therapist; and good physical health, which includes exercise, nutrition, and a regulated stress level.

A naturalistic study from first admission for mania or mixed episode (representing the hospitalised and therefore most severe cases) found that 50% achieved syndromal recovery (no longer meeting criteria for the diagnosis) within six weeks and 98% within two years. 72% achieved symptomatic recovery (no symptoms at all) and 43% achieved functional recovery (regaining of prior occupational and residential status). However, 40% went on to experience a new episode of mania or depression within 2 years of syndromal recovery, and 19% switched phases without recovery (Tohen et. al., 2003).

2.3 LET US SUM UP

The characteristic feature of bipolar disorders, sometimes referred to as manic-depressive disorders, or bipolar affective disorders, is that the person experiences episodes of both depression and mania or hypomania. Mania is a state of elevated mood flight of ideas, and increased psychomotor activity. A hypomanic episode is referred to a period of manic behaviour that is not extreme enough to greatly impair function. In DSM-IV-TR and ICD-10 bipolar disorder is conceptualised as a spectrum of disorders occurring on a continuum. The DSM-IV-TR lists three specific subtypes and one for non-specified:

Bipolar I Disorder

Bipolar I Disorder

Cyclothymia

Bipolar Disorder NOS (Not Otherwise Specified)

Bipolar I Disorder is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. A person with bipolar disorder experiences episodes of mania and, usually, major depressive episodes as well.

Bipolar II Disorder is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes. Hypomanic episodes do not go to the full extremes of mania (*i.e.*, do not usually cause severe social or occupational impairment, and are without psychosis), and this can make Bipolar II more difficult to diagnose. Bipolar II disorder differs from Bipolar I in that – rather than experiencing one or more florid, dramatic manic episodes – the manic behaviour is present to a lesser degree. Cyclothymic disorder is a mild form of bipolar disorder. People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years.

However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder. Bipolar Disorder Not Otherwise Specified (BP-NOS) is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for either bipolar I or II.

The symptoms may not last long enough, or the person may have too few symptoms, to be diagnosed with Bipolar I or II. However, the symptoms are clearly out of the person's normal range of behaviour

Although causes of bipolar disorder likely vary between individuals. But studies suggest that both biological and psychological factors seem to play a role in determining whether a person will develop symptoms of bipolar disorder. Studies conducted on the families of people diagnosed with bipolar disorder show that there is strong tendency for other family members also to have higher than expected risk for a mood disorder of some type including bipolar disorder. Twin studies have indicated a substantial genetic contribution, as well as environmental influence. The concordance rates for these disorders are much higher for identical twins than for fraternal twins. Evidence suggested that psychological factors play a significant role in the development and course of bipolar disorder, and that individual psychosocial variable may interact with genetic dispositions. There is fairly consistent evidence from prospective studies that recent life events and interpersonal relationships contribute to the likelihood of onsets and recurrences of bipolar mood episodes, as they do for onsets and recurrences of unipolar depression.

There are a number of pharmacological and psychotherapeutic techniques used to treat bipolar disorder. An effective maintenance treatment plan includes medication and psychotherapy for preventing relapse and reducing symptom severity.

Some of the types of medications generally used to treat bipolar disorder are:

(1) Mood stabilising medications are usually the first choice to treat bipolar disorder. Lithium, valproic acid or divalproex sodium are commonly used as mood stabilisers in bipolar disorder. (2) Atypical antipsychotic medications are sometimes used to treat symptoms of bipolar disorder. Often, these medications are taken with other medications. (3) Antidepressant medications are also used to treat symptoms of depression in bipolar disorder.

In addition to medication, psychotherapy, or "talk" therapy, can be an effective treatment for bipolar disorder. It can provide support, education, and guidance to people with bipolar disorder and their families.

For many individuals with bipolar disorder a good prognosis results from good treatment, which, in turn, results from an accurate diagnosis. Bipolar disorder can be a severely disabling medical condition. However, many individuals with bipolar disorder can live full and satisfying lives. Quite often, medication is needed to enable this.

2.4 UNIT END QUESTIONS

- 1) What do you mean by bipolar disorder? How does it differ from other mood disorders?
- 2) Discuss the symptoms of bipolar disorders in detail.
- 3) What is manic episode? Differentiate between manic and hypomanic episode.
- 4) Discuss the types of bipolar disorder. Differentiate between bipolar I disorder and bipolar II disorder.
- 5) Explain the causes of bipolar disorder.
- 6) Describe the treatment and prognosis of bipolar disorder.
- 7) Differentiate between bipolar disorder and other forms of depressive disorder.

2.5 GLOSSARY

- Antidepressant medication** : General term for a number of drugs used to relieve depression and to elevate mood.
- Antipsychotic medication** : Group of drugs used to treat patients who show severely disturbed behaviour and thought processes.
- Bipolar disorder** : Mood disorder in which a person experiences both manic and depressive episodes.
- Cognitive Behaviour therapy** : Therapy based on altering cognitive dysfunctional thoughts and cognitive disorders.
- Cyclothymic disorder** : A long lasting disorder that includes both mania and depressive episodes, neither of which meet the criteria for major episodes. Lasts for at least two years.
- Depression** : Pervasive feeling of sadness that may begin after some loss or stressful event, but that continues long afterwards.
- Depressive disorder** : Depressive symptoms that meet diagnostic criteria for either single episode of major depression, or recurrent episodes.
- Dizygotic twins** : Twins that develop from two separate eggs.
- Episodic (disorder)** : Term used to describe a disorder that tends to abate and to recur.
- Major depressive disorder** : A severe depression characterised by dysphoric mood as well as poor appetite, sleep problems, feelings of restlessness, loss of pleasure, loss of energy, feeling of inability to concentrate, recurring thoughts of death or suicide attempts. Depressive episodes occur most of everyday for at least two weeks.
- Mania** : Euphoric, hyperactive state in which an individual's judgment is impaired.
- Hypomania** : A disorder characterised by unusual elevation in mood that is not as extreme as that found in mania.
- Hypomanic episode** : A distinct period of elevated expansive or irritable mood and other manic behaviours that is not severe enough to greatly impair social or occupational functioning and does not require hospitalisation.
- Lithium** : Chemical salt used in the treatment of bipolar disorder.

- Monozygotic twins** : Identical twins developed from one fertilised egg.
- Mood disorder** : One of a group of disorders primarily affecting emotional tones. It can be depression, manic excitement, or both. It may be episodic or chronic.
- Psychotherapy** : Treatment of mental disorders by psychological methods.
- Stress** : Effects created within an organism by the application of a stressor.
- Unipolar disorder** : Mood disorder in which a person experiences only depressive episodes, as opposed to bipolar disorder, in which both manic and depressive episodes occur.

2.6 SUGGESTED READINGS

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